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Essential Health Benefits, and Maryland's Mandated Benefits

Health Care Reform Coordinating Council

Charles Milligan

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Preview of Presentation

- Essential Health Benefits
- Requirements of Providing Essential Health Benefits
- Coverage of “Non-Essential” Health Benefits
- Implications for Maryland’s Mandated Benefits

Essential Health Benefits

"Essential Health Benefits" Defined in ACA, Section 1302

- "The Secretary [of HHS] shall define the essential health benefits, except that such benefits shall include at least the following":
  - Ambulatory Patient Services
  - Emergency Services
  - Hospitalization
  - Maternity and Newborn Care
  - Mental Health and Substance Abuse Disorder Services (including Behavioral Health Treatment)
  - Prescription Drugs
  - Rehabilitative and Habilitative Services and Devices
  - Laboratory Services
  - Preventive and Wellness and Chronic Disease Management
  - Pediatric Services (including Oral and Vision Care)

Steps to Define the "Essential Health Benefits"

- The Essential Health Benefits must be "equal to the scope of benefits provided by a typical employer plan."
- "To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers . . . and provide a report on such survey to the Secretary [of HHS]."
- The Essential Health Benefits must be periodically reviewed and updated by HHS.

Steps to Define the "Essential Health Benefits" continued

- "In defining the Essential Health Benefits, the Secretary shall":
  - Ensure an appropriate balance among the categories
  - Not make decisions that discriminate on the basis of age, disability, or life expectancy
  - Take into account the diversity of the population
  - Ensure that benefits are not denied to individuals against their wishes on the basis of the age, life expectancy, present or predicted disability, degree of medical dependency, or quality of life
  - Ensure that ER cannot require prior authorization, and that out-of-network ER services won't cost the patient more than in-network

Requirements of Providing Essential Health Benefits

Requirements of Providing Essential Health Benefits

- All “qualified health plans” (QHPs) must provide the Essential Health Benefits as of January 1, 2014
- All plans sold in the Exchange must be QHPs; therefore, all Exchange-based plans must include Essential Health Benefits, including individual and small group products
- There cannot be annual or lifetime limits on Essential Health Benefits
- HHS has not yet released any guidance on the specific coverage requirements for the Essential Health Benefit categories

Coverage of "Non-Essential" Health Benefits

Guidelines for Providing "Non-Essential" Benefits

- "A State may require that a qualified health plan offered in [the Exchange] offer benefits in addition to the essential health benefits"
- If so, the state must assume the full cost of the additional benefits, either by paying the individual directly for the marginal cost of the state-added benefits, or by paying the QHP
- This applies to everyone in the Exchange, not just those below 400% of the FPL receiving a subsidy

Implications for Maryland's Mandated Benefits

Maryland's Mandated Benefits

- Under state law, Maryland has 42 mandated benefits; the vast majority are likely to fit within the definition of Essential Health Benefits
- These mandated benefits apply to most regulated products in Maryland (individual market, insured large groups)
- The mandated benefits do not apply to self-insured large groups, association plans issued by an association licensed in another state, or products sold in the small group market (which use the "Comprehensive Standard Health Benefit Plan" as defined by MHCC – small groups also will receive Essential Health Benefits per HHS rules in the Exchange in the future)
- Presently, ***the cost of mandated benefits is not borne by the state***

Source: Maryland Health Care Commission (January 2008). *Study of Mandated Health Insurance Services: A Comparative Evaluation.* Retrieved from http://mhcc.maryland.gov/health_insurance/mandated_1207.pdf

Maryland's Mandated Benefits
continued

- Once HHS defines the Essential Health Benefits, any additional state-mandated benefits that apply to QHPs would create a fiscal impact for the state
- From the general categories detailed in ACA, it is difficult at this time to determine which of Maryland's mandated benefits would fall within the definition of "Essential Health Benefits" and which would fall outside this definition

Implications

- Although the Maryland Health Care Commission (MHCC) has estimated the cost of mandated benefits,* ***without federal guidance clearly defining the Essential Health Benefits***, it is not possible to estimate the potential per capita fiscal effect on Maryland of retaining the existing mandated benefits once the Exchange offers QHPs in 2014.

- Once it is clear which state-mandated benefits fall outside the definition of Essential Health Benefits, Maryland will have to make a choice for each state-mandated benefit:
  - Amend state law to remove the mandate, or
  - Appropriate funds to pay for the additional benefit for people in the Exchange

- This is likely to arise during the 2012 and/or 2013 legislative sessions

*Maryland Health Care Commission (January 2008). *Study of Mandated Health Insurance Services: A Comparative Evaluation.* Retrieved from http://mhcc.maryland.gov/health_insurance/mandated_1207.pdf

Contact Information

Charles Milligan

Executive Director

The Hilltop Institute

University of Maryland, Baltimore County (UMBC)

410.455.6274

cmilligan@hilltop.umbc.edu

www.hilltopinstitute.org